Post-MRMIP Graduate Product Comparative Benefit Matrix (AB 1401) Health Net of California, Inc.
(August 1, 2010 to December 31, 2010)

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, including any related exclusions not contained in this benefit summary, please contact the health care service plan or health insurer and consult the individual plan's evidence of coverage. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefits summary is also available on healthnet.com or the DMHC's website www.dmhc.ca.gov. You may contact the Department of Managed Health Care at (888) HMO-2219 for further assistance regarding the matrix.

Plan Name Health Net of California, Inc.	Plan Contact Phone Number Health Net Member Services 1-800-839-2172
Coverage summary	
Eligibility requirements.	You are eligible to enroll in the Post-MRMIP Graduate Product if you meet any of the following criteria. -Apply for coverage within 63 days of the termination date of previous coverage under the MRMIP and have had continuous coverage under the MRMIP for a period of 36 consecutive months, or -Have been enrolled in a post-MRMIP standard benefit plan and move to an area within the state that is not in the service area of the plan or insurer you previously selected and you apply for coverage within 63 days of termination of previous coverage, or -Have been enrolled in a post-MRMIP standard benefit plan that is no longer available where you reside and apply for coverage within 63 days of the termination date of the previous coverage -Plans may decline coverage if you are eligible for parts A and B of Medicare at the time of application and are not enrolled in Medicare solely due to end stage renal disease. Dependent Coverage—The following dependents may also be enrolled: Subscriber's spouse; Subscriber or spouse's unmarried children; dependent children over age 23 incapable of self-sustaining employment due to certain disabilities. (Consult the Plan's Evidence of Coverage for further information as availability of dependent coverage varies).
The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside.	Premiums charged by plans vary by region and age of subscribers. See Post-MRMIP Graduate Product Rate Chart on this website.

When and under what circumstances benefits cease.	Coverage may be terminated by the Plan under the following circumstances: -Loss of eligibility by Subscriber or enrolled dependents, including (1) Subscriber or dependent(s) move out of the Plan's service area (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) or out of California or (2) Enrolled dependents no longer meet eligibility requirements. -Termination of Plan type by Plan in which Subscriber or dependents enrolled (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) -Non-payment of subscriber charges -Fraud or material misrepresentation (This list represents a general summary. Please consult the Plan's Evidence of Coverage for specific details regarding causes for termination by the Plan).
The terms under which coverage may be renewed.	Coverage under the Plan shall continue, except under the following circumstances: · Loss of eligibility by Subscriber or by enrolled Dependents · Non-payment of subscription charges · Fraud or material misrepresentation · Termination of plan type by Plan in which Subscriber or dependents is enrolled (Please consult the Plan's Evidence of Coverage for further details regarding the process for selection of a different Post-MRMIP Graduate Plan under such circumstances) · Subscriber moves out of the service area
Other coverage that may be available if benefits under the described benefit package cease.	Subject to medical review, if you continue to reside in the Health Net Individual HMO service area you may apply for coverage under a Health Net Individual and Family HMO plan or if you move outside the Health Net HMO service area you may apply for coverage under a Health Net Life PPO insurance plan. Enrollment under these plans is subject to underwriting approval.
The circumstances under which choice in the selection of physicians and providers is permitted.	When you enroll in this Plan, you must select a Health Net contracting Physician Group where you want to receive all of your medical care. That contracting Physician Group will provide or authorize all medical care. You may change your contracting Physician Group at any time.
Coverage Summary	
Lifetime and annual maximums.	$ 200,000 calendar year maximum/$ 750,000 lifetime maximum
Deductibles	None

Benefit Summary (*1)		**Co-payments**	**Limitation** Copayment maximum per calendar year $2,500/covered person and $4,000/family
Professional Services	Physician office visits, including but not limited to preventive care, immunizations, screenings and diagnostic visits.		
	Doctor Office Visits	$20	
	Pediatric Visits	$20	
	Physical Exams	$20	
	Vision or hearing exams	$20	
	Scheduled Well Baby Visits (0 - 23 months)	$15	
	Scheduled Prenatal and first Post-Partum Visit	$15	
	Immunizations	$0	
	Family Planning	$20	
Outpatient Services	Outpatient services, including, but not limited to surgery and treatment, and diagnostic procedures.		
	Outpatient Surgery	$100 per procedure	
	Voluntary Sterilization	$100	
	Voluntary Termination of Pregnancy Visits	$20	
	Physical, Speech, and Occupational Therapy	$20	
	Lab and diagnostic imaging (including x-ray) services	$5	
	Dermatology (UV light treatment)	$5 per encounter	
	Health Education Classes	$0	
	Allergy Injection	$3	
	Allergy Testing	$20	
Hospitalization Services	Inpatient services, including, but not limited to room and board and supplies and inpatient multi-disciplinary rehabilitation services (these are intense coordinated rehabilitation services in more than one therapy, including, but not limited to therapy services provided following a stroke or spinal cord injury).	$200 copay per inpatient day	
	Physician Inpatient Services	No charge	

Emergency Health Coverage	Emergency room services at contracted and non- contracted facilities for medically necessary emergencies	$100 copay per visit	Emergency room. The copayment is waived if the subscriber is admitted directly to the hospital as an inpatient.
Ambulance Services.	Emergency ambulance transport Nonemergency ambulance services	$75 $75	Emergency transport includes both surface and air services.
Prescription Drug Benefits.	Medically necessary drugs prescribed by a physician	**Generic** Retail $10.00 Mail-order $10.00 **Brand** Retail $35.00 Mail-order $35.00 Sexual Dysfunction Drugs 50% Drugs not on the Recommended Drug List are not covered unless approved as medically necessary through Health Net's prior authorization process. If a drug not on the Recommended Drug List is prior authorized, coverage is provided at the same copayments noted above.	Non-Participating Pharmacies are not covered except for emergency or urgent cases and drugs for emergency contraception. Outpatient Prescription Drugs are limited to a quantity not to exceed a 100-day supply Mail Service Prescription Drugs are limited to a quantity not to exceed a 100-day supply Certain drugs are covered only for a 30-day supply
Durable Medical Equipment.	Home medical equipment, including, but not limited to, oxygen, parenteral and enteral nutrition, colostomy and ostomy supplies, corrective prosthetics and aids, orthoses and diabetic supplies. (Some items listed above may be covered under other benefit categories)	20% copay	No benefits are provided for wigs, orthopedic shoes and other supportive devices for the feet (except for diabetes), home testing devices, environmental control equipment, generators, self-help/educational devices, exercise equipment, or any other equipment not primarily medical in nature. Routine maintenance and repair due to damage are not covered, and HMO rental charges in excess of purchase price are not covered.
	Surgically implanted devices and supplies	No charge.	

Benefit Summary Cont.		**Co-payments**	**Limitation**
Mental Health Services	Inpatient and outpatient mental health services, including, but not limited to, mental health parity services (**2) for serious mental disorders and severe emotional disturbances for children.	Inpatient Hospital and Professional (Physician) Services for Severe Mental Illnesses or Serious Emotional Disturbances of a Child $200 copay per inpatient day	
		Inpatient Hospital and Professional (Physician) Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child $200 copay per inpatient day	10 days maximum per calendar year
		Psychiatric Partial Hospitalization for Severe Mental Illnesses or Serious Emotional Disturbances of a Child $0 copay per episode of care	An episode of care is the date from which the patient is admitted to the Partial Hospitalization Program to the date the patient is discharged or leaves the Partial Hospitalization Program. Any services received between these two dates would constitute the episode of care.
		Outpatient Psychiatric Care for Severe Mental Illnesses or Serious Emotional Disturbances of a Child, Initial Visit $20 per visit	Intensive outpatient care is covered under this benefit. Each group therapy session requires only one half of a private office visit Copayment.
		Outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, Initial Visit $20 per visit	15 visit maximum per calendar year. Intensive outpatient care is not covered under this benefit. Each group therapy session requires only one half of a private office visit Copayment.
		Psychological Testing: No charge	

Residential treatment.	Transitional residential recovery services.	Not covered	
Chemical dependence Services			
	Medically necessary inpatient substance abuse medical detoxification is covered.	$200 per day	
Home Health Services.	Home health and hospice care services **(***3).** Medically necessary visits by home health personnel	$0	100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit
Custodial care and skilled nursing facilities	Skilled nursing care and skilled nursing facilities services.	$0	As medically necessary in lieu of hospitalization 100 days per calendar year, except when received through a Hospice Program provided by a Participating Hospice Agency. Custodial care is not covered

(*1) Percentage co-payments represent a percentage of actual cost. In a PPO, percentage co-payments for services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges whichever is less, and enrollees are also responsible for any excess amount.

(**2) Health Plans in California are required by law to provide certain mental health services according to the same terms and conditions as other similar medical benefits. Please contact the individual plan for further information regarding the conditions subject to mental health

(***3) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.